**BEFORE THE APPEALS BOARD**
**FOR THE**
**KANSAS DIVISION OF WORKERS COMPENSATION**

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| **ESTHER MARIE EVANS** | ) | |
| Claimant | ) | |
| | ) | |
| VS. | ) | |
| | ) | |
| **HARRAH'S KANSAS CASINO CORP.** | ) | |
| Respondent | ) | Docket No. 1,024,298 |
| | ) | |
| AND | ) | |
| | ) | |
| **UNITED STATES FIRE INSURANCE CO.** | ) | |
| Insurance Carrier | ) | |

## ORDER

Respondent and its insurance carrier request review of the October 6, 2006 Award by Administrative Law Judge Bryce D. Benedict. The Board heard oral argument on January 9, 2007.

### APPEARANCES

Roger D. Fincher of Topeka, Kansas, appeared for the claimant. Jennifer Arnett of Overland Park, Kansas, appeared for respondent and its insurance carrier.

### RECORD AND STIPULATIONS

The Board has considered the record and adopted the stipulations listed in the Award.

### ISSUES

It was undisputed claimant suffered a work-related injury on June 22, 2003, while working for respondent. But respondent denied receipt of timely written claim for compensation. The parties were also unable to agree on the percentage of claimant's functional impairment and that issue was also litigated.[1] Finally, claimant requested future and unauthorized medical benefits. The Administrative Law Judge (ALJ) found the

[1] Claimant neither alleged nor presented evidence to establish she suffered a work disability (a permanent partial general disability greater than the functional impairment rating) as a result of her accidental injury.

claimant gave respondent timely written claim and awarded claimant compensation for a 10 percent functional impairment to the body as a whole. The ALJ also awarded claimant future medical upon proper application and unauthorized medical up to the statutory maximum of $500 less any amounts already incurred.

The respondent requested Board review of the following issues: (1) whether the claimant filed a timely written claim; (2) nature and extent of claimant's disability, if any; and, (3) whether the claimant is entitled to unauthorized or future medical. Respondent argues the claimant has not sustained her burden of proof that she filed a timely written claim and therefore benefits should be denied. In the alternative, the respondent argues the claimant's permanent impairment should be limited to a 2.5 percent functional impairment. Respondent further argues the claimant has not proved the entitlement to unauthorized medical compensation.

The claimant requested the Board to affirm the ALJ's Award.

## FINDINGS OF FACT AND CONCLUSIONS OF LAW

Having reviewed the evidentiary record filed herein, the stipulations of the parties, and having considered the parties' briefs and oral arguments, the Board makes the following findings of fact and conclusions of law:

The claimant was employed by respondent as a lead server which required that she wait tables and supervise. On June 22, 2003, she was carrying a lot of dishes back to the kitchen and her hands were full. As a consequence, when she reached the kitchen door she kicked it open and immediately experienced pain in her back due to the jarring and twisting motion. She testified that she also experienced pain in her neck and left shoulder. She reported the incident and filled out an injury report. She was sent to the St. Francis Hospital and Medical Center emergency room for treatment.

Claimant was initially diagnosed with lumbosacral strain and provided conservative treatment consisting of medications. On July 24, 2003, she returned to the emergency room and was again provided medications as well as a rehabilitation program and physical therapy. On August 7, 2003, claimant was having cervical pain and physical therapy was ordered for her lumbosacral and cervical spine symptoms. Claimant continued to receive conservative treatment consisting of medications and physical therapy. X-rays of the lumbosacral spine were interpreted as showing no abnormalities and x-rays of the cervical spine revealed straightening of the cervical spine but otherwise were normal. An MRI of the cervical spine was performed on September 13, 2003, and was interpreted to be normal. Claimant was referred for trigger point injections in the cervical spine. On November 17, 2003, claimant was released to her regular job duties without restrictions.

Apparently, claimant sought additional treatment on her own in October 2004 because of left shoulder pain.

As a result of the accidental injury, Dr. Donald T. Mead, who saw claimant on three occasions as she was receiving treatment at the emergency room, opined that claimant suffered a 2.5 percent functional impairment due to her cervical spine injury. The doctor concluded claimant did not suffer any permanent functional impairment to her lumbosacral spine. And the doctor did not impose any permanent restrictions. In a May 11, 2006 letter, the doctor, in pertinent part, explained his rating in the following fashion:

> Using the AMA's Guides to the Evaluation of Permanent Impairment, Fourth Ed., I find the following. She has sustained an injury consistent with a DRE Lumbosacral Category I: Complaints or Symptoms. Using page 102, this translates to a 0% impairment. She has also sustained an injury consistent with a DRE Cervicothoracic Category II: Minor Impairment. As her original injury did not originally involve the cervicothoracic region and she has a history of a motor vehicle accident with cervical injury, it is my medical opinion to a reasonable degree of medical certainty that she has a 2.5% impairment of her whole person as a result of her work-related injury.[2]

The claimant was examined by Dr. Daniel D. Zimmerman on November 9, 2005, at the request of claimant's attorney. Dr. Zimmerman noted claimant continued to have pain and discomfort as well as range of motion restrictions in both her cervical and lumbosacral spine. Dr. Zimmerman opined that as a result of chronic cervical paraspinous myofascitis claimant sustained a 5 percent whole person functional impairment. And the doctor further opined that as a result of chronic lumbar paraspinous myofascitis claimant sustained a 5 percent whole person functional impairment. Using the AMA *Guides*' Combined Value Chart, the doctor concluded claimant sustained a 10 percent whole person functional impairment.

Dr. Zimmerman imposed restrictions which determined claimant was capable of lifting 20 pounds on an occasional basis and 10 pounds on a frequent basis. He noted claimant should avoid captive positioning as well as hyperflexion and hyperextension of the cervical spine. He further noted claimant should avoid frequent bending, stooping, squatting, crawling, kneeling and twisting activities of the lumbosacral spine.

The respondent argues that claimant never provided written claim for the June 22 2003 accidental injury until July 2005. As that exceeds the 200-day statutory limitation for providing written claim the respondent requests that the Board deny claimant benefits.

The written claim statute, K.S.A. 44-520a(a), provides in part:

> No proceedings for compensation shall be maintainable under the workmen's compensation act unless a written claim for compensation shall be served upon the employer by delivering such written claim to him or his duly authorized agent, or by delivering such written claim to him by registered or certified mail within two hundred

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[2] R.H. Trans., Cl. Ex. 1.

> (200) days after the date of the accident, or in cases where compensation payments have been suspended within two hundred (200) days after the date of the last payment of compensation; or within one (1) year after the death of the injured employee if death results from the injury within five (5) years after the date of such accident.

The Kansas Supreme Court has stated that the purpose for written claim is to enable the employer to know about the injury in time to investigate it.[3] The same purpose or function has, of course, been ascribed to the requirement for notice found in K.S.A. 44-520.[4] Written claim is, however, one step beyond notice in that it requires an intent to ask the employer to pay compensation. Another purpose of the written claim statute, therefore, is to require the employee to make a positive claim in writing, that he or she desires to recover under the Workers Compensation Act.[5] But a written claim for compensation need not take on any particular form so long as it is in fact a claim.[6]

In *Fitzwater*[7], the Kansas Supreme Court described the test as follows:

> In determining whether or not a written instrument is in fact a claim the court will examine the writing itself and all the surrounding facts and circumstances, and after considering all these things, place a reasonable interpretation upon them to determine what the parties had in mind. The question is, did the employee have in mind compensation for his injury when the instrument was signed by him or on his behalf, and did he intend by it to ask his employer to pay compensation?

After the accident occurred the claimant met with her supervisor, told him about the incident, completed and signed a First Report of Injury form. The First Report of Injury form contained a description of the accident and injury. By signing the form the claimant's intent was to both satisfy the employer's reporting requirements and to receive authorized medical treatment (compensation). When claimant helped complete and signed the First Report of Injury form for her supervisor claimant obviously believed she was doing what was necessary to receive workers compensation benefits, specifically medical treatment. Claimant testified:

> Q. When you first filled out that form, were you told to fill it out or did you ask to fill it out, or why did you fill it out?

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[3] *Craig v. Electrolux Corporation*, 212 Kan. 75, 82, 510 P.2d 138 (1973).

[4] *Pike v. Gas Service Co.*, 223 Kan. 408, 573 P.2d 1055 (1978).

[5] *See Ricker v. Yellow Transit Freight Lines, Inc.*, 191 Kan. 151, 379 P.2d 279 (1963).

[6] *See Ours v. Lackey*, 213 Kan. 72, 515 P.2d, 1071 (1973).

[7] *Fitzwater v. Boeing Airplane Co.*, 181 Kan. 158, 166, 309 P.2d 681 (1957).

A. It's just a necessary thing, any time - - it's required there - - any time you have an injury at work it's a necessary - - you have to have it done.

Q. And what was your intent in filling it out?

A. So I could get medical, so I could go into - - I had to go to the emergency room.

Q. And did you go to the emergency room right after you filled it out?

A. Yes, I did.

Q. So you filled out the form first and then you went to the emergency room?

A. Correct.[8]

Claimant's intent is evidenced by the fact that she understood that she needed to complete the form in order to obtain medical treatment. Claimant obviously thought this accident report form was prepared for the purpose of receiving workers compensation benefits and that by submitting it as instructed she had completed the requirements necessary to seek medical treatment benefits. In fact, claimant did receive the workers compensation benefit of medical treatment from respondent.

The Board considers the Supreme Court's opinion in *Ours*[9] to be instructive.

> The written claim required by K.S.A. 1972 Supp. 44-520a to be served upon the employer under the Workmen's Compensation Act need not be signed by or for the claimant. The written claim may be presented in any manner and through any person or agency. The claim may be served upon the employer's duly authorized agent.[10]

The Board concludes that the First Report of Injury form which claimant helped her supervisor fill out, signed and delivered to her supervisor was intended to be and does satisfy the purposes of a written claim. Written claimant was, therefore, timely.

Moreover, in response to an inquiry from Ms. Del Biaggio the claimant indicated how many miles she had driven to and from the doctor so she could be reimbursed. Ms. Del Biaggio completed the written document so claimant would receive her mileage reimbursement. The document was signed on claimant's behalf and the intent was clearly

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[8] R.H. Trans. at 13-14.

[9] *Ours v. Lackey,* 213 Kan. 72, 515 P.2d 1071 (1973).

[10] *Id*. at Syl. ¶ 4.

to receive workers compensation benefits. The ALJ determined this document also provided timely written claim. The Board agrees and affirms.

The claimant denied having any ongoing problems with her neck or lower back before the work-related incident at work for respondent. Claimant complains of lower back pain if she sits or stands for too long and that she has constant neck and shoulder pain.

The record contains ratings from Drs. Mead and Zimmerman. Both doctors based their ratings upon the AMA *Guides.* The ALJ adopted Dr. Zimmerman's opinion over Dr. Mead's opinion.

Both doctors recited that their ratings were based upon the AMA *Guides*. But claimant testified that Dr. Mead spent approximately ten minutes with her and did no strength testing. Nor did the doctor use any tools or instruments to determine her range of motion. Instead the doctor had claimant turn her head both directions and lift her arm. Dr. Mead also apparently attributed a portion of claimant's cervical condition to claimant's previous neck injury. But after the automobile accident where she was diagnosed with a muscle strain to her neck she received chiropractic treatment which apparently resolved her condition with no continued complaints.

The ALJ analyzed the medical reports in the following fashion:

> Two physicians rated the Claimant. Dr. Zimmerman gave the Claimant DRE Category II (chronic sprain/strain) 5% impairments to the lumbar and cervical spine, for a 10% whole person impairment. Dr. Mead felt there was no impairment to the lumbar spine, but he gave the Claimant a 5% cervical impairment. Of this 5% he arbitrarily deducted 2.5 percentage points, on the theory that the Claimant had some time in the past suffered a neck injury, and in the present accident her initial complaints had begun in the low back and were later manifested in the cervical region. The evidence before the Court does not indicate that the Claimant's previous neck injury had resulted in any permanent impairment.
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> The Court finds that Dr. Zimmerman's ratings more accurately describes the Claimant's current impairment, and that she has an overall 10% impairment.[11]

As previously noted the claimant testified she suffered a muscle strain in her neck from the car accident which resolved without further problems. The Board agrees with and affirms the ALJ's determination that Dr. Zimmerman's ratings are more persuasive.

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[11] ALJ Award (Oct. 6, 2006) at 3.

Last, claimant is entitled to unauthorized medical compensation up to the statutory maximum upon presentation of itemized billings and proof that the treatment was to cure and relieve the effects of the June 22, 2003 accident.[12]

## AWARD

**WHEREFORE**, it is the decision of the Board that the Award of Administrative Law Judge Bryce D. Benedict dated October 6, 2006, is affirmed.

**IT IS SO ORDERED.**

Dated this _____ day of January 2007.

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BOARD MEMBER

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BOARD MEMBER

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BOARD MEMBER

c: Roger D. Fincher, Attorney for Claimant
Jennifer Arnett, Attorney for Respondent and its Insurance Carrier
Bryce D. Benedict, Administrative Law Judge

[12] K.S.A. 2003 Supp. 44-510h(b)(2).